



CHECKLIST INSTRUCTIONS & APPLICATION TO ESTABLISH A MEDICATION AIDE TRAINING PROGRAM

Pursuant to Virginia nursing regulation [18 VAC 90-60-40](#) the Board may accept an application to establish a Medication Aide Training Program that meets the program requirements. An application must be received by the Board at least ninety (90) days prior to the first course offering.

REQUIREMENTS are listed below to submit an application to establish a Medication Aide Training Program.
Check applicable COMPLETED items that are included with your application:

<input type="checkbox"/>	Completed Application and required fee (\$500): acceptable fees include payment by check or money order made payable to <i>Treasurer of Virginia</i> . An application will not be reviewed or considered until you have submitted payment and fees are non-refundable .
<input type="checkbox"/>	Complete information provided with the application regarding instructional staff that meet the requirements as outlined in 18 VAC 90-60-50. <i>Qualified</i> instructors must hold a current active unrestricted license as a Pharmacist, Registered Nurse (RN) or Licensed Practical (LPN) with a Virginia license or license with multi-state privilege (in accordance with the <i>Nurse Licensure Compact</i>). <i>Primary</i> qualified instructors must have at least three (3) years experience dispensing or administering medications.
<input type="checkbox"/>	Complete information provided with the application regarding program curricula that meets the requirements as outlined in 18 VAC 90-60-60. An approved program must include a minimum of 68 hours of instruction and training.

ADDITIONAL INFORMATION:

- License application processing times: minimum of 90 **business** days to complete.
- Documents submitted with the application are property of the Board and cannot be returned.
- An incomplete application for licensure will be retained on file only as required for audit. If not completed within one year, a new application may be necessary.
- Nursing laws and regulations may be obtained at www.dhp.virginia.gov/nursing.

THIS COMPLETED INSTRUCTION CHECKLIST MUST BE SUBMITTED APPLICATION



Virginia Department of
Health Professions
Board of Nursing

Suite 300
9960 Mayland Drive
Perimeter Center
Henrico, Virginia 23233
(804) 367-4515
www.dhp.virginia.gov/nursing

APPLICATION – TO ESTABLISH MEDICATION AIDE TRAINING PROGRAM

FOR OFFICE USE ONLY (FINANCE DIVISION)

FOR OFFICE USE ONLY (VBON STAFF)

Fee paid:

☐ \$500

Applicant ID#:

Receipt #:

Approved:

Date:

I hereby submit an application to establish a Medication Aide Training Program in the Commonwealth of Virginia. The following information in support of my application is submitted with a **check or money order** made payable to the *Treasurer of Virginia* in the amount of **\$500**. The fees are non-refundable.

APPLICANT - Please provide all information on this application. Print legibly or type.

Application Type: ☐ Medication Aide Training Program

Program Name:

Address of Record (Mailing Address):

City:

State:

Zip:

Phone
Number:

Program Contact Name:

Title:

Email Address:

PROGRAM ELEMENTS

Physical Location of Facility (if different from above):

Proposed Date of First Class:

Faculty to Learner Classroom Ratio:

Faculty to Learner Clinical Ratio:

CLINICAL RESOURCE USED FOR STUDENT CLINICAL EXPERIENCES

Name of Assisted Living Facility:	Address:	Type of Facility (phone and fax #s)

STUDENT LEARNER IDENTIFICATION

Briefly describe how learners are identified and recognizable to clients, visitors and staff when in the clinical setting:

INSTRUCTIONAL STAFF

Primary Instructor Name:

Primary Instructor holds an active (check applicable items):

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Virginia RN/LPN License #:

Expiration Date:

☐

Compact Multi-State RN/LPN License #:

State:

Expiration Date:

☐

Pharmacist License #:

Expiration Date:

WORK EXPERIENCE (PAST 3 YEARS):

Dates
(From/To):

Employer Address & Phone #:

Type of Facility:

Type of Clients:

Duties:

TRAINING EXPERIENCE (Primary Instructor)

Section A (Train the Trainer Coursework)

Dates
(From/To):

School Location:

Course Title/Description:

Clock Hours:

Credit Hrs (CEUs):

Section B (Adult Training Experience within the past 3 years)

Dates (From/To):	Adult Populations Taught:	Agency & Location:	Duties:

Secondary Instructional Staff Name:

Secondary Instructor holds an active (check applicable items):

<input type="checkbox"/>	Virginia RN/LPN License #:		Expiration Date:
<input type="checkbox"/>	Compact Multi-State RN/LPN License #:	State:	Expiration Date:
<input type="checkbox"/>	Pharmacist License #:		Expiration Date:

DIRECT PATIENT CARE EXPERIENCE (PAST 3 YEARS) Secondary Instructor:

Dates (From/To):	Employer Address & Phone #:	Direct Care Experience:

TRAINING EXPERIENCE (Secondary Instructor)

Section A (Train the Trainer Coursework):
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Dates (From/To):	School Location:	Course Title/Description:	Clock Hours:	Credit Hrs (CEUs):

Section B (Adult Training Experience within the past 5 years):

Dates (From/To):	Adult Populations Taught:	Agency & Location:	Duties:

RECORDS OF GRADUATES' PERFORMANCE

a. Describe record keeping system for maintaining reports from the testing service of the overall (not individual) performance of graduates on the **state approved competency evaluation**:

b. Briefly describe how skill records for individual graduates are maintained including providing a copy to graduates:

RECORDS OF DISPOSITION OF COMPLAINTS:

Briefly describe the procedure and record keeping system used for showing disposition of complaints against the medication aide training program:

CERTIFICATION

I certify that the information in this application, including attachments, accurately represents the medication aide training program for which approval by the Virginia Board of Nursing is being requested:

Signature of Administrative Officer or Program Coordinator:	Date:
Email Address:	Phone #: